MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Daniel Peter Swan

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Daniel Peter Swan;
b) Mr Swan died as a result of a motor vehicle crash;
c) The cause of Mr Swan's death was multiple blunt traumatic injuries; and
d) Mr Swan died on 13 May 2018 near 2879 West Tamar Highway, Loira, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Swan's death. The evidence includes an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records and reports; the results of toxicological analysis of samples taken at autopsy and from the other driver involved; and forensic and photographic evidence.

Mr Swan, aged 28 years, partner to Tammy, loving son and brother and friend to many, died when the Toyota HiLux he was driving was hit by another vehicle.

He was travelling north on the West Tamar Highway in fine and dry weather in the area of Loira, towing a trailer with two enduro motor cycles on it. Mr Swan's vehicle was mechanically sound, he was wearing a seat belt, had neither drugs nor alcohol in his body, was not speeding and was wholly in his correct lane.

Travelling in the opposite direction was Graeme John Stronach. Mr Stronach was driving a mechanically sound Toyota LandCruiser 4 wheel drive. He was not speeding either, nor affected by drugs or alcohol. Witnesses saw nothing unusual about his driving until, inexplicably, he veered into Mr Swan's path.

Accident reconstruction suggests, and I accept, that Mr Swan must have perceived Mr Stronach's vehicle in his lane as he braked and steered the HiLux to the left of his lane. However, he was unable to avoid Mr Stronach's LandCruiser and the two vehicles collided.

Both vehicles were effectively destroyed in the collision. A member of the public who had witnessed the crash called 000. Police and emergency services were quickly on the scene. Despite the best efforts of members of the public and emergency services personnel, Mr Swan could not be saved and died shortly after the arrival of Police and Ambulance Tasmania officers at the scene. Mr Stronach was very badly injured. When spoken to by investigators nearly a month after the crash (he had been too badly injured to be spoken to any earlier) he said he had no memory of the crash. He was unable to explain why his vehicle had crossed to the wrong side of the road.

Mr Swan's body was photographed *in situ* as part of the investigative process, extracted from the wreck of the HiLux cab and transported by mortuary ambulance to the Launceston General Hospital where it was formally identified. Following that procedure Mr Swan's body was transported to the morgue at the Royal Hobart Hospital where an autopsy was carried out by experienced forensic pathologist Dr Donald MacGillivray Ritchey. Dr Ritchey found that the cause of Mr Swan's death was multiple blunt traumatic injuries. The injuries which caused Mr Swan's death were most prominent on the right side of his body. Samples taken at autopsy were subsequently toxicologically analysed at the laboratory of Forensic Science Service Tasmania. No alcohol or drugs (illicit or prescription) were found to have been present in those samples.

A blood sample taken from Mr Stronach after his admission to hospital was also toxicologically analysed and had a similar result.

A review of Mr Stronach's medical records does not suggest he was, prior to the happening of the crash, unfit to drive. He had been regularly reviewed and passed fit to hold a Dangerous Goods Licence under the provisions of the *Dangerous Goods (Road and Rail Transport) Act* 2010 (and its predecessor), most recently in late 2011, when his medical records record that he was 'fit for [an] unconditional licence'.

I do note that in October 2018, a number of months after the happening of the crash, Mr Stronach was diagnosed as suffering from obstructive sleep apnoea. However, there is no evidence that Mr Stronach was suffering from that condition on 13 May 2018 nor that it caused or contributed to his veering onto the wrong side of the road.

Despite a careful and comprehensive investigation of the circumstances surrounding Mr Swan's tragic death, it has been impossible to identify just why it was Mr Stronach's vehicle travelled into the incorrect lane. As should be clear from what I have already said in this finding I am satisfied that alcohol, speed and illicit drugs played no role in the happening of the crash. Both vehicles were mechanically sound at the time of the crash. The road surface was in a good

condition and the weather conditions did not cause or contribute to the happening of the crash. Finally, there is no evidence that the use (or misuse) of mobile telephones caused or contributed to the happening of the crash.

The impact of Mr Swan's death upon all those who loved him, and whose lives he touched, is powerfully expressed in the victim impact statements made by his mother, father and sister provided to me as part of the Coronial brief.

Comments and Recommendations

I extend my appreciation to investigating officer 1/C Constable Nigel Housego for his investigation and report.

The circumstances of Mr Swan's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere and respectful condolences to the family and loved ones of Mr Swan.

Dated 12 September 2019 at Hobart in the State of Tasmania.

Simon Cooper
Coroner